Practice Improvement Protocol 2

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services

Effective October 18, 1995
Last Revised April 3, 2003

I. Service Population

Diagnosis: Attention-Deficit/Hyperactivity Disorder (ADHD) 314.01, 314.9, 314.00.

II. Desired Outcome:

A. Change in Target Signs and Symptoms

Observable decrease in symptoms of hyperactivity-impulsivity and/or improvement in attention span.

B. Functional Improvement

The child/adolescent will be able to maintain behavior appropriate to developmental level in multiple settings, including home, school, work or social settings.

C. Environmental Support

Parent(s), family members, teachers, and other members of the child's community will be active members of the child's service plan and will have developed an understanding of the child's condition and realistic behavioral expectations, and learned and demonstrated successful behavior techniques, communication and parenting skills, to be used during and after termination of therapy in managing ADHD at home, in school and in social situations. The home environment will be modified to accommodate the clinical needs of the child.

III. Major Differential Diagnoses and Co-Morbid Conditions

Mood Disorders
Conduct Disorder
Generalized Anxiety Disorder
Oppositional Defiant Disorder
Post Traumatic Stress Disorder
V Codes (e.g. Parent/Child Relational Problem)

IV. Recommended Practice and Coordination

A. Behavioral Health Services

1. A thorough and comprehensive assessment of all domains of a child's life must be made before a diagnosis is given. The core of the assessment should be the parental interview, as the diagnosis rests primarily on observations of those closest to the child and resulting clinical judgment. The child's behavior in home, school, and community settings is evaluated with respect to the features of ADHD, and co-morbid conditions common to this diagnosis are reviewed. Family functioning and its potential effect on symptoms is reviewed. Information from the school, regarding the child's behavior and the appropriateness of the learning environment, is obtained. The use of the Conners Scale or other behavioral rating scales is particularly helpful in measuring baseline functioning and subsequent improvement.

   Therapeutic strategies generally should utilize a broad-based range of interventions that may include:

   - Psycho-Educational approaches
   - Parent training in behavioral management skills
   - Classroom interventions
   - Cognitive behavioral therapy
   - Social skills training
   - Individual psychotherapy of the child
   - Family therapy
   - Living skills training
   - Health promotion with a focus on medication education and compliance and health-promoting activities
   - Peer and family support
   - Respite
   - Other methods of intervention and treatment to address the specific identified needs of the child and family.

All services provided should be consistent with the Arizona Principles and should rest, to the extent possible, on community-based, natural supports, and respect for the child and family's unique cultural heritage and needs.

2. A release of information should be obtained from the legal guardian to communicate with preschool or school staff to document behavior that is affecting academic performance; this communication should occur at the beginning of treatment and at prescribed intervals thereafter. To as great an extent as possible, school staff should be included in the child/family team and in implementation of the behavior-shaping program.

3. The child/family team should develop a detailed and comprehensive treatment plan consistent with the desired individualized outcomes.

4. Studies consistently demonstrate the effectiveness of psychotropic medications, especially when augmented by the therapeutic strategies outlined above.

    - Stimulants are first-line treatments. A high percentage of children and adolescents respond to the first medication tried. Methylphenidate (Ritalin) and Dexedrine have similar benefits and side effects. Long-acting stimulants (Ritalin ER, Concerta ER, Metadate ER, etc.) minimize rebound and provide continuity of effectiveness, but may prolong appetite suppression, insomnia and other side effects. Long and short-acting agents can be combined to provide individualized symptom coverage. There is no research to support the combined use of Methylphenidate and Dexedrine.

    - Other medications are used as second-line treatment. Buproprion has been used successfully, especially in children whose primary symptoms are impulsive in nature. Numerous clinical trials have shown tricyclics to be effective in treating ADHD but have a host of potential side effects for which a child must be carefully assessed. There is some evidence to support that the alpha adrenergic agents such as Clonidine (Catapres) or Guanfacine (Tenex) have

efficacy. Special consideration should be given to coordinating care with the child's Primary Care Provider (PCP) when using tricyclics or alpha adrenergics.

- Psychiatrists may serve as consultants to the PCP when the latter is evaluating for ADHD or prescribing.

- Psychiatrists are encouraged to be actively involved in the child/family team process as participating members when possible, or as active and well-informed consultants.

- Medication Interventions should rarely be considered as the sole treatment. Rather, medications should be seen as a supplement to overall strategies that include behavioral interventions, parenting, and environmental components, especially in the earliest phases of treatment.

5. If there is no improvement after 3 months of intervention, the intervention and diagnosis should be reevaluated.

B. Medical Health Services

1. All relevant information, including the initial assessments and treatment plan, must be communicated to the primary care provider to ensure coordination of services.

2. Under the Psychotropic Medication Initiative, Primary Care Providers (PCPs) are able to treat ADHD within their scope of practice and level of comfort. Care provided by the RBHA in addition to medications prescribed by the PCP should be carefully coordinated. Behavioral updates by the child/family team, school personnel, and community supports should be provided to the PCP prior to, or at the time of, scheduled appointments.

C. Collateral Resources/Ancillary Services

1. Protection & Advocacy

Report to Child or Adult Protective Services (CPS or APS) must be made when there is suspicion of neglect or abuse, including medical or emotional abuse. For open CPS or APS cases, the protective services case plan must be coordinated with behavioral health services. CPS case managers must be invited to all behavioral health services staffings and reviews.

2. Division of Developmental Disabilities

If the individual is not yet enrolled in DDD and mental retardation or autism is diagnosed, referral to DDD should be made for eligibility determination. If DDD is providing services related to the developmental disability, such services must be coordinated with behavioral health services. DDD support coordinators must be invited to all behavioral health services staffings and reviews. All relevant information, including the initial assessments and treatment plan, must be communicated to DDD to ensure coordination of services. Per the ADHS/DES/DDD IGA and Operational Procedure Manual, for DDD/ALTCS individuals, the DDD support coordinator is the lead case manager.

3. Probation, Parole, Correctional Facility, or Other Civil/Criminal Court

If court, probation and/or parole officers are involved with the individual, conditions of probation, parole and related services should be coordinated with behavioral health services. Representatives from involved agencies may participate in the child/family team at the request of the parent/guardian.

4. AHCCCS/ALTCS

Referral to ALTCS should be made for eligibility determination if there is evidence of long-standing medical impairment indicating a need for ALTCS services. If ALTCS is providing services, such services should be coordinated with behavioral health services.

5. Education

The parent/legal guardian will be assisted in eliciting the school district's cooperation. This will include the school's participation in the initial and ongoing evaluation and interventions. The parent may also request the school to provide a comprehensive evaluation to determine special education eligibility, IQ testing, or an accommodation assessment. The behavioral health professional should participate in the development of the Individual Education Plan to assist the school in maintaining the individual in the least restrictive individual educational setting.

6. Vocational Rehabilitation

Vocational training may be available through the school to individuals who are under the age of 16 and designated as emotionally handicapped (EH). For persons 16 and over, referral to vocational rehabilitation services should be considered and services coordinated, if appropriate.